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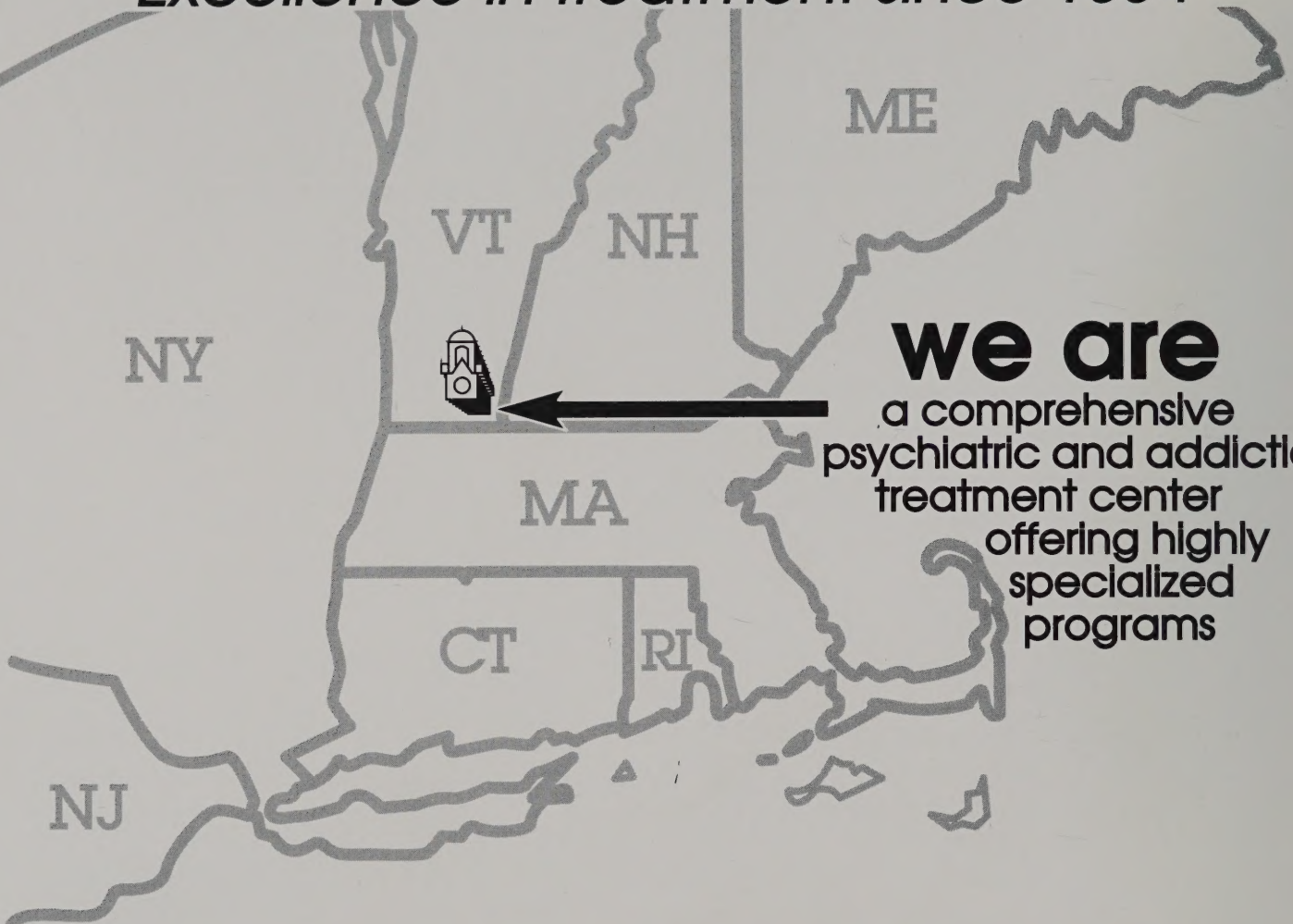

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THE HAMPDEN HIPPOCRAT

SEPTEMBER-OCTOBER 1990
VOLUME XXXXV NO. 10

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On our cover is the Shriner's Hospital in Springfield, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1990-1991 SEASON

DISTRICT MEETING

PLACE:	**CHEZ JOSEF** Shoemaker Lane Agawam, MA
DATE:	Tuesday, September 25, 1990
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m., Spouses are welcome!
SPEAKER:	RANDOLPH D. SMOAK, JR., M.D., Chairman American Medical Association Political Action Committee
SUBJECT:	National Legislative Update

NOTE: If you must cancel your dinner reservation, please call the office before noon on September 25th. If the cancellation is not made, you will be BILLED for your dinner.

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Open Letter To Hampden District Physicians

In 1989, more Hampden District physicians gave more money to the United Way campaign than ever before.

Congratulations and thank you. That performance was another tangible demonstration of Massachusetts' Doctors: Committed to Excellence... Committed to You".

For 1990, the needs are even greater, particularly given the state of our economy. No, we can't fill the whole gap ourselves. But what we can do is try to increase our number of contributors and try to increase each contribution—just a little.

I'm in the process of contacting each of you regarding this year's campaign.

If you helped us last year, please stay with us and, if you can, try to help just a little bit more.

If you couldn't help us last year, please join us in 1990. Let's continue to grow. ■

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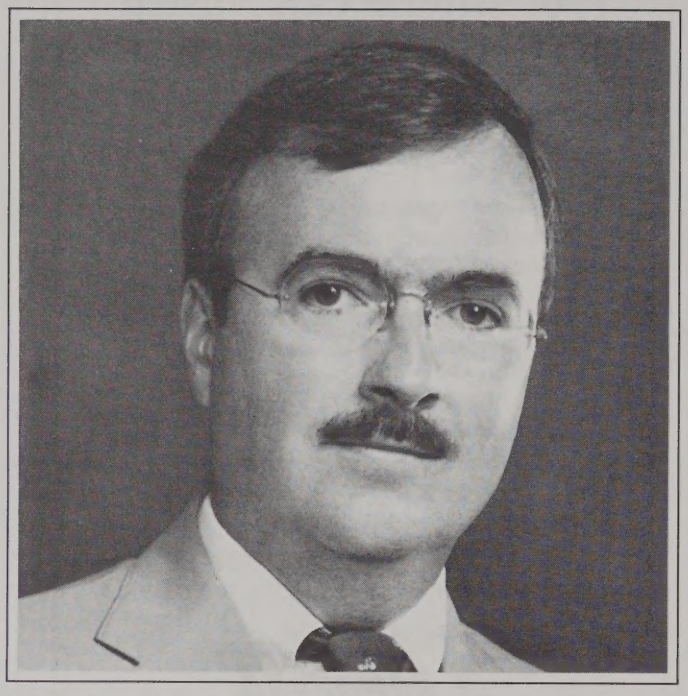
HDMS President's Message



Joseph P. Keenan, M.D., President

Massachusetts has the lowest bond rating in the United States, and in Boston "It's business as usual." Three hundred million was cut from social services in the Commonwealth, and it will be interesting to see how this effects the Medicaid program and the "vendors".

It is frustrating to see how this drama is being acted out in Boston with the politicians trying to please all the special interest groups. It seems there is very little room for rational discourse. The usual rules of common sense and elementary bookkeeping are thrown out the window when the politicians start talking about the state budget. It is a simple fact of life that you can't spend money that you don't have; however, this fundamental truth seems to be beyond the comprehension of our leaders. Generally speaking, a person's desires and wants are unlimited, but their resources are not. Therefore, a person or a state has to prioritize needs and make decisions about allocating their resources in meeting their needs.

A lack of perspective prevents one from having a clear view of the solutions to pressing social problems. A very interesting example of this played itself out in a little rural community west of Springfield recently. A private non-profit organization (state supported) had the idea to purchase a 1.3 million dollar country estate to open an innovative school for troubled adolescents. As part of the public discourse, it was stated that the cost per pupil per year was $100,000. Once again, it was noted that the source of the tuition would be state tax dollars. The proposal was being pushed during the past year at the same time the state of Massachusetts was financially paralyzed by the budget crunch impasse.

Treating these troubled adolescents, meeting their needs and helping them to become productive members of society is the obligation of society, but it must be done in a cost effective manner. Distribution of scarce resources should be done as the basis of need and not on the basis of pressure from special interest groups. When the cost to educate one student in an "innovative" program costs the same as the tuition at Harvard for five students, I would say that program should be re-examined again. One should not be called reactionary to demand that value received for services be commensurate with the tax dollars spent.

While in Springfield earlier this year, the President Elect of the American Medical Association pointed out that in Massachusetts there were 32 "optional" benefits that have been mandated by the politicians in Massachusetts. Rather then try to constructively create a basic medical

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program to meet the needs of the indigent and disabled of Massachusetts, we expend our limited resources paying for "optional" benefits. Rather then using our limited resources to buy vaccine, we pay taxi fares.

These shenanigans have not gone unnoticed by the population at large. When the tax dollars already collected are not being prudently spent, it makes the average taxpayer very hesitant to vote for more tax increases. If tax monies already received are not productively directed to those with the greatest need, increases will be rejected. Proposition 2½ tax over-ride will be rejected as we have seen time and time again, as the taxpayers vent their frustration at the perceived inefficiency of state government.

But what do I mean by "Business as usual in Boston?"—Tax and spend!! Don't evaluate effectiveness of state supported programs, just throw more money at the problem. If anyone questions the budget items, call them heartless. Try to confuse the issue as much as possible by creating "straw man" type arguments. Don't enter into rational discourse that might lead to solutions—enter into name calling and try to placate the most vocal special interest groups—because we all know that is where the vote lies.

Who suffers when this drama is acted out? We all do. Our culture suffers when those with serious needs who are on the outside, the mentally retarded and handicapped, are left underserved. When are our leaders going to act like leaders and stop the name calling and political posturing? We are all going to wait and hope-but don't hold your breath. ■

Medical Assistants To Be Recognized

The Hampden Chapter of the American Association of Medical Assistants (AAMA) has designated October 15-19 as National Medical Assistants Week. Medical Assistants Day is Wednesday, October 17. National Medical Assistants Week, began in 1982, is observed in 44 states and the District of Columbia and over 400 chapters nationwide.

Medical assistants work in doctors offices, outpatient clinics and ambulatory facilities performing a wide variety of clinical and administrative duties. Locally, the Hampden Chapter has planned a meeting at Springfield Technical College on October 17, 1990, 7:00 p.m. with guest speaker Marilyn Pooler, R.N., CMA-C giving a presentation on confidentiality. CEU's will be available for this lecture.

The AAMA is a nonprofit organization dedicated to the professional advancement of medical assistants and represents the second-fastest growing career in the US today. As the oldest and largest organization for medical assistants, the AAMA acts on behalf of a profession of over 1 million. Its educational services enable members to increase their effectiveness to physicians and their patients.

For further information about the Hampden Chapter M.S.M.A., Inc. contact Darlene K. Mykytiuk, president at 533-2549 wk. or 533-6714 hm. ■

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Shriners Hospital

This is the tenth in a continuing series of articles featuring Western Massachusetts Hospitals

Springfield, Massachusetts

As organizations grow and change over time, so too their objectives. When Shriners Hospitals for Crippled Children opened in Springfield, Massachusetts in 1925, the primary objective was to provide medical care to children with orthopaedic deformities, particularly those recovering from polio. Now, sixty-five years later, pediatric orthopaedic care has become very specialized. As the field changed so did Shriners Hospitals—growing quickly into centers of excellence. With each step that was made in orthopaedics, Shriners Hospitals continued to progress.

With the advent of the great university hospitals, shortly after World War II, the Shriners realized the potential to train orthopaedic surgeons and entered into affiliations with medical schools throughout North America. By establishing its residency programs, teaching was formally added as one of Shriners Hospitals primary objectives.

Research was added to the Shriners Hospitals agenda in the 1960s when the three Burns Institutes opened. In addition to providing care and training residents, these hospitals were involved in sophisticated research projects within the hospitals. By bringing formal laboratory research, as well as clinical research, inside the hospitals, rapid advancements were made in the burns care field. Realizing the effectiveness of this arrangement, Shriners expanded its formal research program into its orthopaedic units.

Committed to remaining at the forefront of the orthopaedic and burn care fields, Shriners Hospitals continued to advance. These three goals of patient care, teaching and research work together to enhance and improve the quality of any good hospital—including Shriners. Frank H. Stelling, M.D., former director of medical affairs for Shriners Hospitals, used the analogy of a three legged stool to view the Shriner's commitment to all three—"remove any one of the legs and the stool will topple."

Through the efforts of Shriners and many other individuals and organizations, the hospitals have grown in number and service. Today the 22 Shriners Hospitals located throughout the United States, in Canada and Mexico, are often referred to as the world's greatest philanthropy.

Since opening in 1925, the Springfield Shriners Hospital has provided treatment for more than 24,000 children. In 1989, the operating budget of the Springfield Unit exceeded 7 million dollars. 687 children were admitted, 585 operations were performed, and 8,218 outpatients were served.

Three years ago it was decided that the existing structure on Carew Street with its 68,000 square feet, did not provide adequate space and plans to replace it began. Ground breaking took place in June of 1988 and the more than 25 million dollar project with 109,000 square feet, state-of-the-art equipment, gait analysis laboratory and advanced treatment programs will be completed in September of 1990. Occupancy will take place in October.

An interdisciplinary approach is used in patient care programs. The hospital is dedicated to helping young patients develop their capabilities at all levels, physically, emotional, and intellectually, and the family is encouraged to become involved in all aspects of the child's care and recovery.

The staff includes orthopaedists and pediatricians as well as other medical specialists and health care professionals. While equipped and staffed to provide care

for virtually all pediatric orthopaedic problems, with the exception of acute trauma, the Springfield Unit has developed a special expertise in the following areas:

Congenital clubfoot
Congenital dislocation of the hip
Limb deficiencies and prosthetic restoration
Myelodysplasia—full-care program
Scoliosis
Adaptive Seating

Some of the other orthopaedic problems most commonly treated at Shriners Hospitals include:

Hip disorders
Hand disorders
Juvenile rheumatoid arthritis
Leg length discrepancies
Metabolic bone disease
Neuromuscular disorders
Skeletal growth abnormalties

Children treated at the Springfield Unit come from all over New England, upper New York State, and from wherever a Shriner finds a child in need of our specialized care. The Hospital, in addition to its inpatient care and outpatient clinics, maintains outreach clinics in San Juan, Puerto Rico, Bangor and Lewiston, Maine, and Utica, New York. These outreach clinics have two purposes—the first is to provide follow-up on an annual basis, and the second is to evaluate new patients. They also provide a service to hundreds of families in that the need to travel to Springfield is eliminated.

The key to the success of the Springfield Unit has always been its dedicated staff. The chief of staff is John M. Roberts, M.D., a graduate of the College of Physicians and Surgeons, Columbia University.

Prior to assuming this position, Dr. Roberts was Surgeon-in-Chief, Division of Pediatric Orthopaedics, Rhode Island Hospital and Acting Chairman, Department of Orthopaedics, at both Rhode Island Hospital and Brown University Program in Medicine. He was also Professor at Brown University in the Departments of Orthopaedics and Pediatrics.

Chief of Staff Emeritus, Leon Kruger, M.D., who served as Chief from 1976 to October 1989, continues his thirty-eight year association with the hospital which began in 1952 when he was a resident.

The active staff of the Springfield Unit is composed of the following orthopaedic surgeons from the Springfield area:

John M. DeWeese, M.D.
Sumner E. Karas, M.D.
Morton D. Lynn, M.D.
Mark J. Pohlman, M.D.
Joseph H. Sklar, M.D.
Steven M. Wenner, M.D.

The consulting medical staff, primarily from our Western Massachusetts area, consists of physicians and surgeons in orthopaedics as well as the various disciplines necessary to complement orthopaedic care.

The Springfield Unit currently has a residency program in orthopaedic surgery with three residents from the Boston University program and one from the Columbian Presbyterian program. In addition to the residents, there is one fellow on the staff.

continued on next page

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Shriners Hospital

continued

The Hospital conducts a number of speciality clinics, each of which is staffed by a physician with expertise in that particular field:

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Cerebral Palsy
Club Foot
Genetic
Growth Discrepancy
Hand
Hip
Lower Limb Deficiency
Metabolic
Myelodysplasia
Rheumatology
Scoliosis
Shoulder
Upper Limb Deficiency
Urology

Most people recognize a Shriner by the red fez they see in a Shrine parade, a Shrine football game, or a Shrine circus. These events are fund-raising activities of the Shriners. The role of the Shriner is to assist in the operation of the hospital, to volunteer to serve on the Board and various committees, and to provide the fund raising necessary to support the system of 22 hospitals. Each Shriner, and there are more than 800,000 in North America, contributes a portion of his dues to hospital support.

Children, regardless of race, religion or relationship to a Shriner, between the ages of infancy and 18 who have a treatable orthopaedic or burn condition may be referred by any physician or may apply directly for care. No charge is ever levied against a family, an insurance carrier, or a governmental agency for care rendered at the hospital. Shriners Hospitals contributions to the the care of children with orthpaedic and burn problems is unique. Truly, it is **the world's greatest philanthropy.**■

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From The MMS Regional Office

Projections indicate that by 1995, 60% of the American population will be covered by a Health Maintenance Organization or a Preferred Provider Organization also referred to as Managed Care Organizations (MCOs). Closer to home, more than 35% of the population of western Massachusetts is currently enrolled in a MCO. Now more than ever it is critical for all western Massachusetts physicians to be aware of the contractual and organizational issues surrounding MCOs. The Massachusetts Medical Society's Physician Contracting Services Program has developed two comprehensive seminars dedicated to education and informing physicians and their office managers about this evolving industry and its effect on their practices.

"**WHAT EVERY PHYSICIAN SHOULD KNOW ABOUT MANAGED CARE CONTRACTS—Includes Alternative Approaches to Contract Provisions,**" is a program which will provide physicians with a primer on contract law, and review of the legal considerations physicians should be aware of in managed care contracts. The program will also include alternative approaches to contract provisions for reimbursement, insolvency, termination and amendments.

"**PHYSICIAN CAPITATION AND SOLVENCY ISSUES IN MANAGED CARE,**" is a program to assist physicians with the evaluation of capitation arrangements and will prepare the physician to identify trouble signs in MCOs. Participants will have the opportunity to learn how capitation arrangements are designed by MCOs, and how to evaluate this reimbursement structure. The program will also address various revenue, expense and plan managment problems which can be indicators of troubled MCOs.

For your convenience, these two half-day seminars will be offered on Wednesday, November 28, 1990 in Holyoke, MA. "**WHAT EVERY PHYSICIAN SHOULD KNOW ABOUT MANAGED CARE CONTRACTS**" will be held from 9:00 a.m.-12:00 p.m. The faculty is Carol W. Phillips, Esq., Westcott and Phillips, Boston, MA. "**PHYSICIAN CAPITATION AND SOLVENCY ISSUES IN MANAGED CARE**" will be held from 1:30 p.m.-5:00 p.m. The faculty includes Diane Stone, MBA, and Barry Scheur, Esq., Scheur Managment Group, Newton, MA. A luncheon will be served. Physicians and/or office managers may attend either one or both of the programs. If you have not received your program brochure by mid-October, please contact Kerin Milesky at 1-800/522-3112, or Yael Miller at 1-800/322-2303.

Currently more than 40% of participating physicians, up from 25% only three years ago, earn up to 49% of their revenues through MCOs. The percentage of physician revenue derived through MCOs will continue to increase as managed care enrollment rises. It is therefore imperative that physicians continue to enhance their understanding and knowledge of managed care contracts, amendments, and reimbursement arrangements, and be able to identify trouble signs. These two programs can help make a positive difference for physicians. ■

Kerin L. Milesky,
Regional Coordinator

Yael R. Miller, MBA
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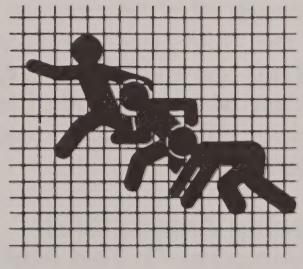

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The Changing Status of Physicians in America and Canada

EDITOR'S NOTE: *In September, 1989, Martin Barkin, a Toronto Urologist and Deputy Minister of Health for the Province of Ontario, and Gregory Slachta, Springfield Urologist and past president of the Hampden District Medical Society debated the Canadian Health Care System and its possible application to U.S. Health Care at the annual meeting of the American Urological Association in Toronto. Dr. Barkin's remarks are reprinted here with the permission of the Association. A summary of Dr. Slachta's remarks will be published in our next issue.*

In any conversation with physicians in North America or Europe, one is struck by the dismay expressed over the generally deteriorating relationship between physicians and society.

This deterioration is largely due to difficulties with third party payors, whether that third party is industry (in the U.S.) or government (in both the U.S. and Canada).

Across Canada during this decade we have seen disputes over tariffs, extra-billing, alternate payment models, availability of hospital resources, differential regional tariffs, caps on billing, residency restrictions, and increased jurisdictions of licensing bodies.

In the U.S., particularly following passage of the HCFA Amendment to the Medicare Act, we have seen the introduction of regulatory, legislative and funding measures which have been equally provocative to the American medical establishment.

In addition to shifting funding mechanisms, our states, provinces and federal governments have passed laws and created agencies and policies that have as their intent the restriction of physician activities.

Add to the reams of red tape a proliferation of reimbursement forms and hassles, a growing liability crisis, managed hospital prospective reimbursement practices, widened quality assurance and professional monitoring, changed payment methods in academic centers, and we see that the practice of medicine is undergoing revolutionary changes that none of us anticipated.

Through all of this, no one can tell the "good guys" from the "bad guys", simply because there are neither good nor bad guys. What is clear is that basic assumptions on which we have based many of our current policies, patterns and practices are being sorely challenged.

Changing Assumptions

Assumption #1: That health care is one of the most significant contributors to health and well-being and needs to be buttressed by structured delivery systems based primarily on health insurance.

Assumption #2: That costs for payments for services to the few who are ill ought to be borne by the many who are not.

But with the wisdom of hindsight, we discovered that no determinant of health is as important as wealth, and that it's opposite, poverty, is a key factor leading to ill health.

A second determinant of health is public policy, those acts which we undertake to protect our collective health—clean air and water, food inspection, sewage disposal, speed limits, labor practices and working conditions, etc. We are becoming much more aggressive and much less tolerant as our knowledge in these areas expand.

A third determinant is individual choice. Our health is determined by what we choose to do, to eat, how we choose to drive. Choice, in the matter of AIDS, is the single most important factor in controlling this disease. Our largest measure of success will derive from how well we can influence personal choice.

The future survival of our species will depend on how well our society addresses these three areas.

The Health Care System

The fourth determinant of health involves the one with which we most closely relate: the health care system.

A new awareness is emerging that this determinant has nowhere near the profound effect on our state of health as the other three. In fact, its effects are qualitatively as well as quantitatively different.

Every year of life expectancy now being gained is marred by two thirds of a year of chronic disability. In Canada, 90% of our health care efforts are geared towards treating and supporting patients who are chronically ill.

Americans, too, are increasingly skeptical about the quality of health care value received.

Lee Iaccoca, Chrysler's chairman, points out that he faces a health care bill that exceeds $4,000 per employee, a cost that adds $500 to the price of every U.S. built car... and that sum is rising.

American-style health care, as it affects the prices of products, each year makes us less and less competitive in world economies. Iaccoca articulates our unspoken fear—that further expenditure on health care (at least as we are now spending it) will harm our collective health more than it will contribute.

Ontario's Cost Problem

Ontario's economy is one of the healthiest in the world exceeding even that of East Germany and Japan. Our publicly funded health care revenues come primarily from various forms of taxes (and now consume virtually all the Province's personal income taxes and gasoline taxes).

Ontario's health care expenditures have been rising at a rate of more than two times inflation. If left unchecked, health care costs by the turn of the century will total more than half of all government expenditures.

Expenditures in Ontario hospitals are now exceeding the rate of rise in the U.S. by two times or more. While U.S. hospital use is falling, Ontario's per capita use of acute bed days is rising, with admittance delays and no reserve capacity.

From 1985 to 1987, payments to physicians increased by $1 billion, over a $2 billion base. This past year, the government set aside an increase of 9.5%, more than $250 million, for increase in physician compensation. As negotiations with the Ontario Medical Association unfolded, it became clear that about $150 million would be spent to pay for increasing numbers of physicians. Our rate of new physicians (a third from out of province and about a quarter from out of country) is almost five times the rate of increase in population.

At the same time, unanticipated shifts in practice patterns also became apparent, such as a 130% increase in cardiovascular services in three years, a 100% increase in ultrasound use, and a 40% increase in ordinary visits.

The U.S. Problem

Ontario's expenditure pattern is being repeated everywhere across North America and Europe, but nowhere has it reached the proportions that it has in the U.S., which spends more per capita on health care than any country in the world (three times more than the U.K. and 41% more than Canada)—yet still has incomplete and sporadic provisions.

This level of expenditure, while high for both our countries, may be a good thing. What is alarming is the rate at which that level is escalating.

When we consider national demographics, those statistics become even more alarming. About 45% of health care dollars are used to care for the 10% of our population over 65. If we continue the current rate of expenditure and style of delivery, Canada's spending on health care just past the turn of the century will reach 15% of the G.N.P., while in the U.S. it will be 25% of the G.N.P. Spending on Medicare alone may surpass the defense budget in the next ten years.

Quality Assurance and Health Outcomes Management

As we become increasingly cost sensitive, many of medicine's most prestigious journals are drawing our attention to a lack of validating data to prove that we are spending our health care dollars wisely. The issue of uncontrolled rates of expenditure increase is made worse by the suspicion that we are spending on the wrong things.

According to *Fortune* magazine, "Half of what the medical profession does is of unverified effectiveness". Joseph Califano believes that more than 25%, or about $200 billion worth, of what we do each year is of unverified effect at best and dangerous at worst.

Some remedies, procedures and practices are clearly effective. But, as Sagan points out, physicians "instinctively expand the indications for these remedies to many more persons than those for whom they are effective." The results: added expense and a "serious deterioration of quality—more complications, more anxieties, more dependencies."

Many corporations and third party payers in the U.S. feel it is now appropriate to double check doctors' recommendations and orders. Rand corporation studies of carotid angiography, carotid endarterectomy, and upper GI endoscopy reveal that anywhere from 17% to over 50% of these procedures were inappropriate.

Wennberg points out that women living in one hospital area in the State of Maine have a 70% chance of having a hysterectomy by the time they reached 70, while for women in another area the percentage is only 20%. (Incidentally, in France it would be less than 5%) In Iowa, regional variations for prostatectomy range from 15% to 60%; for tonsillectomy in Vermont, from 5% to 10%. Recent studies suggest that about 56% of coronary bypasses in the U.S. were either inappropriate or ineffective.

Other studies confirm that the more frequently a procedure is done at a particular center, the more the complication rate and mortality rate improve. Yet a Canadian Urologic Association manpower study showed that many Canadian urologists perform only one to five times a year such technically demanding procedures as percutaneous nephrolithotomy, radical nephrectomy, hypospadias, and radical cancer surgery on the bladder or prostate.

continued on next page

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The Changing Status of Physicians in America and Canada continued

In the U.S., in spite of extensive and well-funded physician opposition, third party payers and Congress have already made a significant impact on this pattern. By introducing different payment incentives such as capitation fees and DRGs, mandatory third party review, and publication of physician and hospital "track records", there has been a substantial shift in the pattern of medical care practices.

A recent review of the impact of these shifts on quality of care shows improvements rather than deterioration in outcomes, despite the fact that anecdotes about discharging patients "quicker and sicker" abound.

The Challenge

The world is changing for physicians in all countries. Systems have changed, awarenesses have changed, values have changed, information bases have changed, technology has changed.

Through my transition from practicing physician to administrator to Deputy Minister I have seen a continuing failure on the part of physicians to participate constructively in the decision-making proces. The resulting vacuum has been filled by others: payors, governments, employers, insurance companies, and other advocacy groups.

Regardless of the complexity of the system, physicians continue to occupy the most significant position of potential influence. I believe this position needs to shift toward cooperative and constructive physician participation in managing the system.

The effects of such a shift could be as significant to health care delivery in North America as similar shifts toward participatory (as opposed to confrontational) labor practices were in changing the face of Japan's auto industry.

Physicians now confront one of the most important challenges in their history—to become partners in the decision-making and a part of the solution. This opportunity is better than being characterized and treated as part of the problem.

I believe that, for physicians, to light at least one candle is better than cursing the darkness with paralyzing rhetoric.

I believe that one of the noblest callings must regain its place as society's most distinguished servant rather than being seen as self-serving.

And, since I am an optimist, I believe that the leadership of our profession, both contemporary and emerging, shares these beliefs. ■

Martin Barkin
Deputy Minister of Health
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The Physician—Patient Relationship and The Law of Confidentiality

EDITOR'S NOTE: *Dennis Anti, Esquire is an attorney.*

In recent years the law of individual privacy has become a subject of profound interest. In medicine, nothing is more private to a patient than the information disclosed to a physician and the records kept by the medical professional to document the patient's condition and treatment. To promote the best interests of the patient and to ensure a climate of trust, physicians urge their patients to be totally candid in their discussions regarding the patient's health. To encourage patient candor, which ultimately results in optimal patient care, a duty has been placed on the physician not to reveal, without the patient's authorization, these most private disclosures.

It is surprising that in this Commonwealth, unlike many other jurisdictions, no legislation has been promulgated which specifically outlines the parameters of physician-patient confidentiality. The law that is available on this subject has been decided by appellate court decisions without the benefit of public debate.

The first case in Massachusetts which directly addressed physician-patient confidentiality was *Alberts v. Devine*, 395 Mass. 59 (1985). In this case the Supreme Judicial Court ruled that unless faced with a serious danger to the patient or to others, a physician has a duty not to disclose, without a patient's consent, medical information gained in the course of the professional relationship. A violation of that duty may give rise to a civil action against the physician or any individual who promotes a violation of the physician's duty of confidentiality and thereby causes injury or loss to the patient. Disclosure of such information may result in the statutory action of Invasion of Privacy which may be brought pursuant to Massachusetts General Laws Chapter 214, Section 1B. It is important to appreciate however, that if the physician determines that either the patient or some other person is "faced with serious danger", unauthorized disclosure of the patient's history would be permitted. However, at this time one can only hypothesize as to how "faced with serious danger" will be interpreted by the Courts since there is no case law now available to provide guidance.

In *Tower v. Hirschhorn*, 397 Mass. 581 (1986), the Supreme Judicial Court applied the principles announced in *Alberts* to a case involving a neurologist who, without authorization, divulged medical information regarding one of her patients. In that case, the doctor disclosed information regarding the patient's psychomotor seizures to an attorney representing an insurance company and a physician retained by the attorney. This information was sought in connection with an automobile tort action for which the patient was seeking damages. The Court found that the defendant physician had unreasonably invaded her patient's privacy by disclosing confidential information regarding the patient's alleged psychomotor seizures as they related to her auto accident. The Court in a footnote wrote:

> We recognize that it is commonplace in the medical profession for physicians to consult with their colleagues regarding the treatment and diagnosis of patients within their care. This exchange of information is desirable as it generally improves the medical care rendered. The dialogue between the defendant (Dr. Hirschhorn) and the (physician retained by the attorney) was different in kind, however. (The physician retained by the attorney) had been retained by the (insurance company) and thus stood in an antagonistic relationship to the plaintiff (patient).

The Court took issue that the physician not only disclosed her patient's medical history without authorization but that the disclosure was to a party who was the patient's adversary in Court.

The third case of importance in discussing physician-patient confidentiality is *Schwartz v. Goldstein*, 400 Mass. 152 (1987). This case was brought by a woman plaintiff alleging medical malpractice by her gynecologist during surgery. During the trial the physician who performed subsequent surgery on the plaintiff was testifying as an expert witness against the defendant doctor. During his testimony and the testimony of others, it became evident that this subsequent treating physician had prior unauthorized conversations with the claims adjuster for the defendant doctor's insurance company. The Court decided first that there was a cause of action against the subsequent treating physician for his breach of confidentiality in discussing the plaintiff's case with the defendant's claims adjuster. Secondly, the plaintiff also had a cause of action against the claims adjuster for inducing a violation of the physician's duty of confidentiality. The Court wrote that, "an opposing party would not be free to engage in clandestine, unauthorized conferences with a plaintiff's physician."

It is crucial to appreciate that once a physician-patient relationship is established, an obligation on the part of the physician arises not to reveal to anyone any medical information obtained in the confidential relationship with the patient. The patient enjoys what is called a privilege, that is, information learned and documented in the confidential relationship by the physician may not be disclosed without proper authorization by the patient. As discussed in *"Tower v. Hirschhorn* above, however, there is an implicit authorization by the patient that his or her physician may disclose otherwise confidential information to other medical care providers involved in patient's care and treatment.

Additionally, if a patient brings a medical malpractice action against a physician, the patient waives the privilege of confidentiality with his or her physician,and all other prior and subsequent treating physicians as to court supervised testimony. The concept of court supervised testimony is of great importance. Court supervision will arise after a claim has been filed in a court

continued

The Physician—Patient Relationship and The Law of Confidentiality continued

or governmental administrative agency. Court supervised testimony includes depositions, production of office and hospital records, responses to interrogatories, and trial testimony.

In a medical malpractice action after suite is initiated by a patient, the defendant physician may disclose otherwise protected patient medical information to his or her defense attorney and medical malpractice insurance claims adjuster. The law allows these exception to the patient's privilege of confidentiality to prevent the patient from concealing relevant medical evidence, and to allow a jury to evaluate all medical evidence available before rendering a verdict.

Non-court supervised testimony should always be avoided without prior authorization of the patient. The most common examples would include contracts by a defendant's attorney and/or insurance carrier with a plaintiff's treating physician in a medical malpractice or personal injury action, without court supervision.

It should be understood that there are no legal ramifications for the substance of the information contained in the physician's records if it is reliable and relevant to the medical history, care, or treatment of the patient. (For example, a physician who notes in his or her records that a patient is a drug abuser or an alcoholic or that a paitent has tested positive for HTLV-III if that information was provided to the physician by the patient or obtained through reliable testing.) Confidentiality is breached only by the unauthorized disclosure of the patient's medical information.

A properly executed authorization by the patient or patient's legal guardian is the appropriate vehicle for the physician to disclose the medical information of the patient. This authorization should be signed by the patient or patient's legal guardian, dated, and specifically describe the documents and records to be disclosed. The physician should retain this authorization on the patient's chart after disclosing the information. Under no circumstances should a physician disclose patient information over the telephone.

Physicians should be aware that the legislature has acknowledged certain medical conditions where more detailed authorization or judicial orders are required before the appropriate disclosure can be made by the medical provider. These situation include:

1. Disclosure of patient testing positive for HLTV-III—Massachusetts General Laws, Chapter III, Section 71F. The written release form shall state that purpose for which the information is being requested and shall be distinguished from written consent for the release of any other medical information.
2. Disclosure of information pertaining to venereal diseases—Massachusetts General Laws, Chapter 111, Section 119.
3. Disclosure of patient's alcohol treatment records—Massachusetts General Laws, Chapter 111B, Section 11.
4. Disclosure of patient's drug rehabilitation records—Massachusetts General Laws, Chapter 111E, Section 18.
5. Disclosure of fetal death—Massachusetts General Laws, Chapter 111, Section 202.
6. Disclosure of patient information by licensed psychologist—Massachusetts General Laws, Chapter 112, Section 129A.
7. Disclosure of Mental Health records of the Department of Mental Health—Massachusetts General Laws, Chapter 123, Section 36.
8. Disclosure of patient information by licensed psychotherapists—Massachusetts General Laws, Chapter 233, Section 20A.

There is one situation where a patient's authorization is not required before a physician can release otherwise privileged medical information regarding a patient. Disclosures by a physicain or other health care providers of information regarding the diagnosis, treatment or condition of a patient in connection with the establishment of eligibility of, or entitlement to public assistance programs or with any other legally required reporting will not be grounds for civil liability including invasion of privacy or violation of physician's duty of confidentiality, even without the consent of the patient. (Massachusetts General Laws, Chapter 112, Section 12G.)

Although our legislature has not promulgated legislation outlining the standards for establishing the law of confidentiality as it applies to the physician-patient relationship, the Courts of this Commonwealth have established some principles for guidance.

First, unless there is a serious danger to the patient or others, unauthorized disclosure of a patient's medical information is not permitted. If damages flow from the unauthorized disclosures, the medical provider could be held civilly liable to the patient.

Second, if a third party induces a medical provider to disclose without authorization a patient's medical information, that third party may also be held civilly liable to the patient for damages.

Third, the medical provider should appreciate that confidential medical information related by the patient that is to be included in office records has no legal consequence unless that information is inappropriately disclosed by the medical provider. Without court supervision to ensure appropriate disclosure of a patient's medical information, the medical provider should only respond in written form after a duly executed authorization is completed by the patient or his or her legal guardian.

The physician-patient relationship is a sacred trust which is treasured by both the physician and the patient. Breaching this trust will not only endanger the patient's health if he or she is not candid with their physician, but may also subject the medical provider to litigation which could have been easily prevented. ■

Dennis R. Anti, Esquire

How They See Us

EDITOR'S NOTE: *This is the first of a series of articles solicited from members of professions who come in contact with physicians. This article is a compilation of thoughts from nursing home professionals, arranged by Matthew J. Leahey, President, Ring Nursing Home.*

The following is a collection of thoughts from a variety of nursing home professionals, including administrators, nurse managers and social workers who interact with Hampden County physicians every day. They range from personal feelings to some that reflect a programmatic approach.

In 1984 the National Academy of Sciences issued a report on long term care in America. It served as a basis for much that is contained in OBRA '87, new Federal guidelines that will require, among other things, increased administrative participation by nursing home medical directors. Among their findings was that the single consistent factor, present in the nusing homes which were determined as providing the best patient care, was meaningful physician involvement. Many Hampden County physicians have made this a priority for years.

■ Nursing home residents, and the professional staff of the homes who care for them, are increasingly appreciative of the commitment and cooperation of physicians who attend them.

Nursing home professionals like and appreciate physicians who come to visit their patients in a timely manner as required by the people who survey our records. We like physicians who document changes in condition in a comprehensive way and fill in the spaces on the History and Physical Exam forms. We respect the physicians who work with us on developing and implementing meaningful advanced directives that will fulfill the wishes of patients who want to see their final years lived out in dignity and consistent with the ethical beliefs of their families and themselves.

We appreciate physicians who take an active role in working with our staff in establising a meaningful plan of care. We like physicians who put up with the many calls our nursing staff make to them in order to obtain the orders necessary to carefully and delicately regulate medications for patients whose behaviors are problems for themselves, or other residents, and inhibit our ability to provide routine professional nursing care.

We are grateful to physicians who cooperate and work with us so closely. We are painfully aware that current reimbursement doesn't really encourage or reward much in the way of their cooperation or effort. We are also very aware that we have not always done a perfect job in communicating the "what and why" of our needs. For years it may have seemed our primary concern was the timely visit or signature. We have been turning to the physicians to try to get them to help solve our problems at some pretty odd times. I can imagine what it must be like to be a covering physician, unfamiliar with a patient, receiving a call from a nurse new to a floor, with a poorly-defined patient problem, seeking immediate resolution, late on a Saturday night, Christmas Eve, New Years Eve, or during a Stage West performance. I know all of those things have happened. Hampden County physicians speak their minds.

■ Physicians, and the organizations that represent them, have always promoted the value of maintaining individual patient relationships and the importance of the indefinable factors that they bring to the patients' physical and emotional well-being. We enthusiastically agree. This has been made clear through years of observing the positive effect that accompany a physician's lifetime care of a patient when it is continued following a nursing home admission. If an attending physician does not follow a patient after admission to a nursing home, we can arrange for another physician to assume the responsibility to ensure paper compliance. Most of the physicians who do accept new admissions to nursing homes are not only extremely competent practitioners, but are very familiar with, and faithful about, the required documentation. What these new physicians can never do, no matter how qualified, is duplicate the lifetime relationship that existed between physician and patient previous to the patient's nursing home admission.

■ Between July 1st of this year and January 1st of 1991, most of the rules nursing homes live by will change: mandated Medicare participation, nurses aid certification, O.B.R.A. implementation, and finally, patient-based case mix reimbursement, a prospective payment system based on individual patient acuity that will greatly increase our need to document daily care.

If we are going to really make it all work, we must identify the need for a dual commitment on the part of physicians and nursing home professionals:

1. Increased awareness among the physician community to the needs of frail elders; and
2. The establishment of more effective communication between physicians and the nursing home professional teams that are entrusted with the around-the-clock, day in and day out care of patients.

■ In general, I find doctors are approachable. At least half of those I have needed to make contacts with are informative and willing to give the time, and are not impatient with receiving information or with questions being asked. There are still a few doctors who appear to be condescending toward staff members. It's difficult to discern if this is because they have a problem relating to women or if they generally hold themselves in higher esteem. ■

A New Antitrust Issue

EDITOR'S NOTE: *Dr. Lorne Smith is Chairman of the Insurance Committee and a former President of the Hampden District Medical Society.*

My office is regularly visited by well dressed young representatives of Managed Care Organizations offering opportunities to participate in their "Product". They leave lengthy contracts. They are either uncertain or vague about which hospitals will be in the plan or where tertiary care will be available. They are also vague as to which other physicians in the area have joined. If I have time, I ask a few questions starting with the word "Why". The answer is inevitably that the decision in question was made at a higher level and is therfore something that cannot be discussed by the person with whom I am speaking.

It seems to me that there is a significant potential problem for all parties in the development of Managed Care Plans involving physicians in private practice if there is a mismatch between the physicians recruited and the hospitals included in the Plan.

As president of the medical staff of a local community hospital, I attempted to address the issue. I tried to establish a means of communication between a cross section of the medical staff and the hospital administration to examine managed care proposals to determine whether there was sufficient interest on the part of the medical staff to justify the hospital's entering into a contractual relationship with the plan in question. My reasoning was shared by the hospital administration but not the hospital attorneys. They were extremely upset by the idea and insisted that no such discussions take place, citing the possibility of antitrust violation. My plan was effectively killed.

We now have the ludicrous situation of hospitals entering into managed care plans without knowing whether anyone on their medical staff will be involved. The marketing of the Plans must be difficult if a significant mismatch is obvious.

As we are all aware, being the target of an antitrust allegation is a very serious problem for a physician regardless of the merits of the case. The remote possibility of an Antitrust violation is sufficient to discourage almost any collective action on the part of physicians. It is predicted that almost all patients, including those in government programs, will soon be enrolled in Managed Care Programs. Unless there is a change in the ground rules, physicians in private practice will be at a distinct disadvantage.

I am reminded of earlier, more innocent times. I was a House Officer in New York City in the early 1960's. We rotated through a large Municipal Hospital. All pay for House Officers was low. There were no fringe benefits. A group of residents from one of the larger city hospitals approached the City Government seeking better wages and fringe benefits. As I recall they hired a good attorney to represent their case. There was not a threat of withholding services. Robert Wagner was Mayor. His Administration did the sensible thing. The interns and residents as we were known were placed on a list of employee groups along with the Sanitation Workers, Police, Firefighters, etc. with whom labor contracts were negotiated. There was, as the result of these negotiations, a quantum increase in salary and the inclusion of fringe benefits—including Health Insurance. These improvements spread rapidly to the House Staffs of the private hospitals in the Big Apple. As I recall, an ongoing mechanism of bargaining was established that may well still be in existence.

If there is a roll for private practice in the future of Health Care in this country, some means of escaping the threat of Antitrust Allegation every time physicians act in concert must be found.

The priorities of both our state and national societies should include Legislation that excludes physicians from Antitrust Allegations at least in the narrowed sphere of managed care negotiations ■

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Arnold S. Relman, M.D. To Retire

The Massachusetts Medical Society (MMS) announced that Arnold S. Relman, M.D., will retire as editor-in-chief of the *New England Journal of Medicine* in June 1991. Dr. Relman disclosed his decision to retire to the Committee on Publications meeting of the Medical Society July 11, 1990. The Massachusetts Medical Society is owner and publisher of the *New England Journal of Medicine.*

Dr. Relman was appointed editor of the *New England Journal of Medicine* in 1977 and became editor-in-chief in 1988.

"I know his colleagues join me in wishing him well in this new endeavor," said Barry M. Manuel, M.D. president of the Massachusetts Medical Society. "The *Journal* has documented not only advances in medical practice, but the social, political and economic forces that effect medicine. The standards that Arnold Relman has set for that reporting will be hard to match."

Dr. Manuel will establish a search committee shortly to name a new editor-in-chief. Under Dr. Relman, the *Journal* has increased its circulation to a current level of more than 225,000 subscribers worldwide. The *New England Journal of Medicine* is one of the world's oldest and most respected journals. ■

IN MEMORIAM

GEORGE A. VASSOS, JR., M.D., passed away in July. Dr. Vassos served as Chief Medical Examiner for the Second Hampden District, and was a former chairman of the Springfield Municipal Hospital Board of Trustees. His wife, Helen, died in 1989. He leaves two sons, Dr. George A. Vassos III, and Dr. Douglas K. Vassos.

BENJAMIN ALPORT, M.D., died in February, 1990. Dr. Alport practiced opthalmology. He had received distinguished service awards from Tufts University and from Baystate Medical Center. He was a director of the United Hebrew School. He gave the impetus to the founding of the Orthoptic Clinic by the Lion's Club. Dr. Alport leaves his wife, Frances and his children, Stephen, Susan, and Deborah. ■

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The Physician Census is a cooperative effort of the Society, the state's Board of Registration in Medicine and Executive Office of Consumer Affairs, and the American Medical Association.

The pre-printed Census forms are to be mailed in September 1990 to active and inactive physicians licensed in Massachusetts. The results are to be released by the end of 1990.

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BORN: January 23, 1967
PREMED: Yale University 1988
MEDICAL: Boston University School of Medicine 1988-1992
STUDENT

Frederick W. Harwick, D.O.
Wing Memorial Hospital
Wright Street
Palmer, MA 01069

BORN: February 16, 1955
PREMED: Muhlenberg College, Pennsylvania 1973-1977
MEDICAL: Philadelphia College of Osteopathic Medicine 1978-1982
INTERNSHIP: Richmond Heights General Hospital, Ohio 1982-1983
SPECIALTY: Family Practice

Garry M. Bombardier, M.D.
10 Hospital Drive
Holyoke, MA 01040

BORN: March 10, 1949
PREMED: University of Massachusetts 1967-1971
MEDICAL: Albany Medical College of Union University 1971-1975
INTERNSHIP: St. Francis Medical Center, Connecticut 1975-1976
RESIDENCY: St. Francis Medical Center 1976-1978
FELLOWSHIP: St. Francis Medical Center 1978-1979
SPECIALTY: Internal Medicine

Duane F. Dixon
Springfield Anesthesia Service
333 East Columbus Avenue
Springfield, MA 01105

BORN: May 13, 1959
PREMED: Rutgers College, New Jersey 1977-1981
MEDICAL: New Jersey Medical School 1981-1986
INTERNSHIP: Baystate Medical Center 1986-1987
RESIDENCY: Baystate Medical Center 1987-1990
SPECIALTY: Anesthesiology

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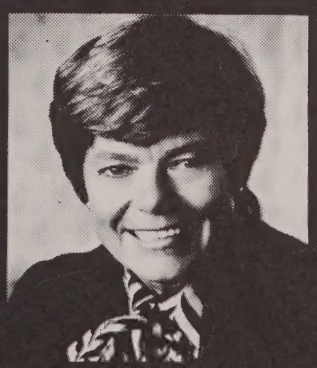

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BORN: March 28, 1953
PREMED: University of Massachusetts 1971-1975
Clark University 1971-1975
MEDICAL: Columbia University 1975-1977
State University of New York-Downstate 1979-1983
INTERNSHIP: Temple University Hospital, Pennsylvania 1983-1984 (Categorical Medicine)
RESIDENCY: University of Kentucky Medical Center 1984-1986 (Preventive/Occupational Medicine)
Baystate Medical Center 1988-1990 (Internal Medicine)
Center for Disease Control 1988-1990
SPECIALTY: Occupational Medicine/Internal Medicine

Paul A. Koerner, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: August 27, 1952
PREMED: Bucknell University, Pennsylvania 1970-1974
MEDICAL: Temple University School of Medicine, Pennsylvania 1974-1978
INTERNSHIP: Western Pennsylvania Hospital 1978-1980
RESIDENCY: Hahnemann University, Pennsylvania 1980-1983
FELLOWSHIP: Parkland Memorial Hospital, Texas 1983-1984
SPECIALTY: Orthopedic Surgery

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PREMED: Holy Cross College, Massachusetts 1976-1980
MEDICAL: Tufts Medical School 1984-1987
INTERNSHIP: St. Elizabeth's Hospital 1987-1988
RESIDENCY: St. Elizabeth's Hospital 1988-6/90
SPECIALTY: Internal Medicine

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BORN: September 20, 1960
PREMED: Massachusetts Institute of Technology 1978-1982
MEDICAL: New York University School of Medicine 1982-1986
INTERNSHIP: University of Wisconsin 1986-1987
RESIDENCY: University of Wisconsin 1987-6/90
SPECIALTY: Anesthesiology

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BORN: July 23, 1958
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INTERNSHIP: Thomas Jefferson University Hospital, Pennsylvania 1984-1986
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SPECIALTY: General Surgery

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